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ABSTRACT

Standards are presented for self evaluation of low vision services as part of the National Accreditation Council accreditation program. Participants rank their services on a scale from excellent to minimal for the following areas: planning and organization, personnel, low vision evaluation, continuing services, facilities and equipment, and program evaluation. A final section calls for ideas on programing changes to improve the service. (CL)

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SELF-STUDY AND EVALUATION GUIDE | 1981 Edition

Low Vision Service

NATIONAL ACCREDITATION COUNCIL
For Agencies Serving the Blind and Visually Handicapped

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New York, N.Y. 10016

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INSTRUCTIONS

PRELIMINARY STEPS. Two steps should precede the use of this section in a self-study.

1. All persons involved in the self-study should become familiar with *Section A, Manual of Procedures* for an understanding of the background and purposes of accreditation and the procedures to be followed in conducting a self-study using the various self-study and evaluation guides published by the National Accreditation Council.

2. Members of the self-study committee assigned to complete this guide should review the organization's statement of philosophy of service as a basic reference for the self-study.

RATING. In the parentheses ( ) preceding each standard, enter the letter representing the final evaluation reached in the self-study. Often, improvements are implemented during the self-study. In such instances, the ratings selected should represent conditions at the end of the self-study.

E – Excellent. The standard is met fully or exceeded.

S – Satisfactory. The standard is met substantially.

A – Adequate. The standard is met fairly well but some improvements could be made.

P – Poor. The standard is met only partially and improvements should be made.

M – Minimal. The standard is met to a small extent or not at all and substantial improvements should be made.

NA – Not Applicable. The standard does not apply for reasons stated under *Comments.*

COMMENTS. Throughout the section, space is provided after groups of standards for written comments. An explanation of the rating or any important feature or characteristic of the program can be noted here. Also, the reason why a particular standard or group of standards is not felt to apply to the organization can be outlined.

PROGRAMMING FOR IMPROVEMENT. This concluding part of the guide contains seven questions which provide an opportunity to list the outstanding features of the program and how it benefits the persons served. The questions also call for a listing of past improvements and those which are yet to be accomplished. Plans for improvement initiated as a result of the self-study should be included.

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LIST OF SELF-STUDY AND EVALUATION GUIDES

This self-study and evaluation guide is designed to be used in combination with other guides, listed below, available from the National Accreditation Council. An organization undertaking a self-study in applying for accreditation needs to use the following: A, either B-1 or B-2, all C sections, those D sections for the services provided, an E form for certain staff members and F.

Section	Title and Edition
A	Manual of Procedures (1979)
B-1	Agency Profile (1979)
B-2	School Profile (1979)
C-1	Function and Structure (1977)
C-2	Accounting for Services and Finances (1976)
C-3	Personnel Administration and Volunteer Service (1980)
C-4	Physical Facilities (1975)
C-5	Public Relations and Fund Raising (1968)
D-2A	Orientation and Mobility Services (1977)
D-2B	Orientation and Mobility Services (Dog Guide Programs: 1968)
D-3	Rehabilitation Centers (1968: revision in process)
D-4	Workshop Services (1976)
D-5	Social Services (1981)
D-6	Vocational Services (1975)
D-7	Production of Reading Materials (1970: revision in process)
D-8	Rehabilitation Teaching Services (1977)
D-9	Low Vision Service (1981)
D-15	Preschool Services (from Birth to Six: 1979)
D-16	Other Service Program (1979)
D-20	Curriculum Planning and Evaluation (1979)
D-21	Program for Multihandicapped Students (1979)
D-22	Program for K-12 Students (1979)
D-23	Program for Independent Living (1979)
D-24	Educational Resources Program (1979)
D-25	Leisure Education (1979)
D-26	Residential Living Program (1979)
D-27	Health Services (1979)
D-28	Educational Diagnostic and Counseling Services (1979)
E	Individual Staff Member Information Form (1977)
F	Evaluation Summary and Report (1979)

Sections D-2A through D-9 are applicable primarily to "agencies" and D-20 through D-28 primarily to "schools". D-15 is used for preschool services in any setting. Similarly, D-16 is used by all organizations for services for which NAC does not have specific standards such as radio reading service or special summer program.

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We wish to express our thanks to everyone who helped in our two year project to develop standards for a low vision service. The National Accreditation Council (NAC) involves many people and organizations in developing and maintaining its accreditation standards.

While it is impossible to cite the names of all those who contributed to the formulation of these standards, we'd like to acknowledge special appreciation to those who played key roles in this undertaking.

The Commission on Standards provides overall direction to NAC's standard-setting activities. It assigns the work of developing (or revising) particular sets of standards to special national technical committees. In the Fall of 1979, such a committee was formed to prepare standards for a low vision service. Chaired by Milton Jahoda, himself a person who has low vision and executive director of a NAC accredited agency which operates a low vision service, the committee included a balanced mix of nationally recognized consumers, ophthalmologists, optometrists, and other professionals in the field. Many of these are leaders in consumer and professional organizations concerned with low vision.

At its first meeting in November, 1979, the committee drew up a draft of proposed standards for national review to extend from January through September, 1980. Then, NAC's newsletter, *The Standard-Bearer,* invited all interested persons to order a copy of the draft and send in their suggestions for improving the proposed standards.

We appreciate very much the assistance of these other national publications which carried notices about the national review: *Journal of Visual Impairment and Blindness; The Argus; The Ophthalmologist; AAWB News and Views; AAWB Interest Group Nine Newsletter; Dialogue; Braille Forum; American Journal of Occupational Therapy; Low Vision Abstracts and the American Optometric Association News.* As a result of this publicity, over 300 copies of the draft were distributed during the national review period.

Personnel from a number of NAC accredited organizations contributed ideas for improving the draft standards. Among them were; the Virginia Department for the Visually Handicapped; Michigan School for the Blind; New Hampshire Association for the Blind; New York Association for the Blind; Hawaii State Services for the Blind Branch and the South Dakota Division of Services for the Visually Impaired.

Individuals in private practice, staff members of low vision services, faculty of various college and university programs and others submitted comments and suggestions on the draft.

During the Helen Keller Centennial Congress in June, 1980, committee members Milton Jahoda, Eleanor Faye, Randall Jose and Natalie Barraga drew up a preliminary list of definitions of key terms for a low vision service. They were assisted by: George Hellinger, O.D., Director, Optometric Service, Low Vision Clinic, Industrial Home for the Blind, Brooklyn, N.Y., William V. Padula, O.D., National Consultant on Low Vision, American Foundation for the Blind, New York City and Clare M. Hood, R.N., Administrator, Lighthouse Low Vision Service, New York Association for the Blind.

In the Fall of 1980, all of the substantial input received during the national review was compiled for the committee's review and in March, 1981, the committee met for the last time to prepare its final recommendations. We give special thanks to the two NAC accredited agencies in Dallas, the Dallas County Association for the Blind and the Dallas Service for Visually Handicapped Children, for their hospitality during this final meeting.

The committee took into account all of the ideas generated by the national review. We thank the committee for the enthusiasm, professional expertise and dedication to improved services shown by its members.

The Commission on Standards, accepted the committees final recommendations in May, 1981 and in June, 1981 NAC's Board adopted the standards for use in accreditation.

Finally we wish to acknowledge, with deep gratitude, those whose financial support made this work possible:

William Randolph Hearst Foundation, New York, New York;

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INTRODUCTION

The development of these standards for a low vision service fills an important gap in the accreditation program of the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC). In recent years, a growing number of specialized agencies for the blind have established low vision services in recognition of the very real contributions these services can make to the independence, productivity and general life satisfaction of persons who have low vision.

The precise number of Americans who might benefit from low vision services is not known. Estimates published in the early 1970's by the American Foundation for the Blind (AFB), placed the number at about five million persons. [1] More recent estimates, including those of NAC's committee which developed these standards, are more conservative and favor the total of some two million persons who have low vision. [2] This is a substantial number of people although only a small percentage of the total population. Delivery of quality services to such a "low incidence" group may help explain why this population is considered to be "underserved," as illustrated by the finding that only about 35,000 persons received low vision services in 1977. [3]

Nevertheless, the number of low vision services grew significantly during the 1970's. In 1973, the National Society to Prevent Blindness (NSPB) found 114 such services in operation throughout the country. [4] By 1977, the number had risen to over 160 according to the survey done by the American Foundation for the Blind. [3] About half of these services were located in organizations whose primary function is provision of health care such as hospitals, health maintenance organizations and ophthalmologic or optometric groups. The next most common type of "parent" organization is that of rehabilitation agencies followed by institutions engaged in professional preparation of ophthalmologists or optometrists. Voluntary agencies for the blind experienced the greatest rate of growth in new services established during the years between these two surveys.

The professional literature reflects the increasing depth of knowledge and experience about the characteristics of quality low vision services. In 1962, NSPB published 14 basic standards which have been updated and incorporated where appropriate in these standards. [5] The American Academy of Ophthalmology, American Academy of Optometry, American Association of Workers for the Blind, Association for Education of the Visually Handicapped and American Council of the Blind all have established committees or interest groups reflecting growing attention to low vision services. Also, internships, continuing education programs and certification of various low vision service personnel have been established or are being explored. The Association of Schools and Colleges of Optometry has worked on curriculum materials in rehabilitative optometry. At least one college of optometry is considering establishment of a masters degree in vision rehabilitation for persons from a number of different disciplines.

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1. *The New Outlook for the Blind*. New York, American Foundation for the Blind, May 1974, p. 229.
2. Genensky Samuel M. See selected references.
3. Kirchner, Corrine and Phillips, Beth. See Selected references.
4. National Society to Prevent Blindness. See Selected references.
5. Ophthalmological Committee on Low Vision Aids. See selected references.

In 1977, the AFB Advisory Committee on Low Vision Services called on NAC to formulate accreditation standards for low vision services. Considerable encouragement for this project was received from agencies for the blind, professional organizations and leaders in low vision work in ophthalmology and optometry. In 1979, the work began.

The following are definitions of key terms used in these standards:

1. Low Vision. Reduced visual acuity and/or abnormal visual fields resulting from a disorder in the visual system.

2. Low Vision Patient. An individual who has an eye disorder which reduced visual performance and which cannot be corrected by conventional means.

3. Low Vision Aid. Any device which enables the low vision patient to improve visual performance.

4. Optical Aid. A device (lens combinations, prism, mirror or electro-optical instrument) that, by virtue of its optical properties, raises the low vision patient's level of visual performance.

5. Low Vision Service. A series of comprehensive tests, evaluations and multidisciplinary referrals provided for the low vision patient which has as its objective a prescription of low vision aids and instruction/training programs to enhance the low vision patient's performance.

6. Low Vision Clinician. A licensed ophthalmologist or optometrist who has specialized training and experience in low vision examination and prescription techniques.

7. Low Vision Assistant. A person who works under the direction of a low vision clinician and who has specialized training and experience in instructing low vision patients in the use of prescribed low vision aids to improve visual performance.

The low vision clinician and low vision assistant are among the personnel called for by these standards. Also noted in part two of the standards are clinical director of low vision service and administrator of low vision service. The identification of four positions is not intended to imply that every low vision service must have four different individuals assigned to these jobs. A low vision clinician, for example, could serve as a clinical director of a low vision service, administrator of the service and low vision assistant. Also, the low vision assistant could serve as administrator of the service. The administrator, who must understand the operations and management of a low vision service, could be someone else than a low vision clinician or a low vision assistant.

It is hoped that these standards will be useful to low vision services located in a variety of settings, including hospitals, postsecondary education institutions, general rehabilitation agencies and both group and private practices. Community planning and funding bodies may find them helpful in planning and evaluating low vision services.

As noted earlier, however, the standards have been designed primarily for use in NAC's accreditation program. The basic eligibility criteria to apply for accreditation are summarized as follows:

1. Legal incorporation or official status as a unit of government;

2. Primary function is serving blind or visually handicapped persons;

3. Provision of one or more services encompassed by NAC standards;

4. Presence of a governing authority;

5. Possession of a discrete name.

Any low vision service which operates as an independent entity or as part of a larger institution may apply for NAC accreditation provided it meets the above criteria. It should be noted that the accreditation program of the Council on Clinical Optometric Care (a unit of the American Optometric Association) covers vision care in a variety of health delivery systems involving optometric care for a wide range of needs of the general population. NAC's standards, on the other hand, are designed to be applied to highly specialized services and institutions specifically reaching a small part of the total population needing vision care.

In addition to meeting the above eligibility criteria to apply for NAC accreditation, a low vision service which is independently run, or is a part of a multi-function "parent" institution is evaluated in relation to NAC's standards for management (C-1 through C-5) and *Section D-9, Low Vision Service*. Also, if the low vision service is part of an organization whose major purpose is to serve blind or visually handicapped persons, the entire organization must apply for accreditation and its other services are included as covered by NAC's other applicable service standards (D-2A through D-28).

The decision on whether or not accreditation is awarded is made by NAC's Commission on Accreditation based on a finding that the applicant substantially meets NAC's standards for quality services, responsible management and public accountability.

Further information about the accreditation process is available from NAC.

DESCRIPTIVE PROFILE

NAME OF SERVICE _____

TITLES AND MAJOR DUTIES OF PERSONNEL RESPONSIBLE FOR:

Administration of the service _____

_____

_____

_____

Direction of low vision clinical care _____

_____

_____

_____

IS THERE AN ADVISORY COMMITTEE? ____ *No.* ____ *Yes. If yes, indicate number of members* _____ *and the committee's official name* _____

_____

GEOGRAPHIC AREA SERVED _____

_____

_____

FACILITIES USED

____ *Central Office*

____ *Satellite office(s)*

____ *Mobile unit(s)*

____ *Home (including institutions)*

____ *School, workplace, etc.*

____ *Patient transportation service*

SCHEDULE OF HOURS _____

_____

_____

_____

DESCRIPTIVE PROFILE (continued)

NUMBER OF PATIENTS SERVED (in last fiscal year ending _____)

Vision Status		*Age Groups*			
Legally blind only	_____	*Birth - 5*	_____	*45 - 64*	_____
		6 - 21	_____	*65 - 84*	_____
Other persons with low vision	_____	*22 - 44*	_____	*85 & over*	_____
Total	_____			*Total*	_____

NUMBER OF IN-PERSON CONTACTS WITH PATIENTS IN LAST FISCAL YEAR _____

EXPENSES AND INCOME OF THE SERVICE FOR LAST FISCAL YEAR

Total expenses $ _____ *Total income* $ _____

ADDITIONAL PROGRAM COMPONENTS. *Check or specify below any components for which structured provisions are made in addition to the basic aspects of the low vision service which are encompassed by the standards.*

___ *Preparation of professionals or paraprofessionals in low vision services*

___ *Research to improve or develop low vision aids, low vision evaluation techniques or patient instruction methods*

___ *Publication or other formal sharing of research results*

___ *Ongoing activities to inform personnel of related or other services and the general public about the capabilities and problems of persons who have low vision*

___ *Other (specify)* _____

_____

_____

_____

_____

_____

THE STANDARDS

PART 1. PLANNING AND ORGANIZATION

( ) 1.1 PHILOSOPHY. The low vision service is consistent with the statement of philosophy of service approved by the governing authority.

Comments:

( ) 1.2 PURPOSE. The goal and objectives of the service are set forth clearly in writing.

( ) 1.2.1 Goal. The goal of the service is to provide persons who have low vision with timely and specialized services which assist them to attain optimum visual functioning for daily living, education, social activities, work, recreation and leisure.

Comments:

( ) 1.2.2 Objectives. Specific objectives are set for the service which support the goal and are commensurate with the established need and available resources.

Comments:

( ) 1.3 PERSONS SERVED. Service is made available to persons who have low vision.

( ) 1.3.1 Age groups. Service is made available to persons of all ages, or the particular age groups served are specified in writing.

( ) 1.3.2 Special Populations. The service assists persons who have other impairments or handicaps in addition to low vision or it cooperates with others in the same geographical area that do so.

( ) 1.3.3 Economic Status. Provisions are made to serve, inform or refer persons from all economic levels, on an equal basis.

( ) 1.3.4 Eligibility Criteria. Eligibility criteria, other than vision, and referral procedures are described clearly in writing.

Comments:

( ) 1.3.5 Outreach and casefinding. A vigorous program is implemented for regularly informing persons who have low vision and other key publics about the service.

( ) 1.3.5.1 Requests for information and service receive timely and appropriate responses.

( ) 1.3.5.2 The organization's overall public information and education program publicizes the low vision service.

( ) 1.3.5.3 Specific efforts are made to inform special populations.

( ) 1.3.5.4 Specific efforts are made to inform and elicit the cooperation of the professional communities involved in services such as eye care, geriatrics, pediatrics, rehabilitation, special education and prevention of blindness.

SUPPLEMENTARY INFORMATION. Check those to whom information about the low vision service was provided in the last fiscal year.

___ *Agencies and schools for the blind and visually handicapped*
___ *Community schools*
___ *Drivers licensing agencies*
___ *Employer groups*
___ *Health and medical care services*
___ *Information and referral services*
___ *Labor unions*
___ *Librarians*
___ *The media*
___ *Ophthalmologists*
___ *Optometrists*
___ *Organizations of blind and visually handicapped persons*
___ *Orientation and mobility specialists*
___ *Parent groups*
___ *Prevention of blindness agencies*
___ *Psychologists*
___ *Rehabilitation counselors*
___ *Recreation facilities*
___ *Service clubs (Lions, Delta Gamma, Rotary, etc.)*
___ *Services for the aging (senior centers, nursing homes and other institutions)*
___ *Shopping centers*
___ *Social workers*
___ *Social service agencies*
___ *Teachers of blind and visually handicapped children*
___ *Other (specify)*

Comments:

( ) 1.3.6 Communications. Throughout all phases of the low vision service, every effort is made to focus on the needs and concerns of the individual patient and/or the family or guardian by providing clear information and answering questions.

( ) 1.3.6.1 Interpreters of languages, including sign language, are made available whenever needed.

Comments:

( ) 1.4 ADMISSIONS PROCEDURES. The procedural manual sets forth the eligibility criteria and the steps in the admissions process.

( ) 1.4.1 Referrals. Criteria for referral are established and data are collected about sources of referral for use in evaluation, outreach and casefinding efforts.

( ) 1.4.2 Initial contact. After a referral has been received, initial contact is established promptly with the applicant, or in the case of a child, with the family or guardian.

Comments:

( ) 1.4.3 Preparation for First Visit. The applicant is informed about materials, procedures and instructions needed to prepare for the first visit.

( ) 1.4.3.1 A recent report of ophthalmological examination and treatment is secured.

( ) 1.4.3.2 If there is no recent ophthalmological report, or if there are any questions about proceeding with low vision service, the applicant is referred to the ophthalmological consultant.

Comments:

( ) 1.4.3.3 The applicant is advised to bring along appropriate identification cards, claims numbers, documents related to medical care benefits, spectacles and low vision aids that the applicant has used.

( ) 1.4.3.4 A large print description of the admissions process and fee schedule, when applicable, is distributed to the applicant.

Comments:

( ) 1.4.3.5 An appointment is scheduled promptly after the eye report is received and reviewed by an appropriate person.

( ) 1.4.3.6 Travel directions to the low vision service are given and/or arrangements are made for transportation.

Comments:

( ) 1.4.4 Registration. Registration procedures are utilized to help determine and facilitate the most effective way to serve the person who has low vision.

( ) 1.4.4.1 During registration the patient is encouraged to express reasons for coming to the low vision service, informed of the purpose and procedures of the service and given appropriate answers to questions.

( ) 1.4.4.2 Registration includes recording of identifying data and the opening of an individualized service record or chart.

Comments:

( ) 1.4.4.3 Information is obtained for initiating claims for payment by insurers, other organizations, programs or resources including individual fee payment when appropriate.

( ) 1.4.4.4 Registration provides for collection of data for the organization's management information system for reporting of low vision services in accordance with *Section C-2, Accounting for Services and Finances.*

Comments:

( ) 1.5 PLANNING. Various methods are used for systematic planning of the low vision service.

( ) 1.5.1 Long Range Planning. A written long range plan establishes major program objectives and projects the human, physical and financial resources needed to achieve them.

( ) 1.5.1.1 The major long range objectives of this service are coordinated with the organization's overall long range plan.

( ) 1.5.1.2 The plan extends for a specified time beyond the present fiscal year and is updated at stated intervals.

Comments:

( ) 1.5.2 Annual Planning. A specific written program and financial plan for the service is prepared for each fiscal year.

( ) 1.5.2.1 The annual plan includes a statement of measurable objectives to accomplish the stated goal.

Comments:

( ) 1.5.3 Short Range Planning. Personnel communicate through conferences, written and verbal exchanges for day to day planning, problem solving and coordination with other services provided by the organization.

Comments:

( ) 1.5.4 Interagency Coordination. Efforts are made on a continuing basis to coordinate planning and delivery of low vision services with the programs of related organizations on the local, state, regional and national levels.

Comments:

( ) 1.5.5 Professional Communication. Efforts are made on a continuing basis to maintain communications about individual patients concerning their service plans, progress and outcomes with other professional personnel involved with each patient, and general information is shared with professional groups, services and preparation programs.

Comments:

( ) 1.6 PARTICIPATION IN PLANNING. Structured processes are used to assure meaningful input to program planning activities from persons who represent a wide range of knowledge, experience and interest including the organization's governing authority, staff, consultants, service volunteers, persons served and other consumers and the community.

Comments:

( ) 1.7 ORGANIZATION. The service is clearly and purposefully organized.

( ) 1.7.1 Structure. The service is an integral part of the organization's administration structure and is clearly identified in the official organization chart.

Comments:

( ) 1.7.2 Administration. Provisions are made within the service for effective and orderly administration, quality clinical care, instruction/ training and related services.

Comments:

( ) 1.8 PROCEDURAL MANUAL. Policies and procedures, consistent with professional standards and ethics for administration, low vision evaluation, instruction, followup and related services are set forth in a written manual in media conveniently accessible for all personnel.

Comments:

( ) 1.9 RECORD OF SERVICE. A centralized, confidential service record, reflecting all low vision services, is maintained for each person served from application through end of service and any subsequent contacts.

Comments:

PART 2. PERSONNEL

( ) 2.1 ESSENTIAL FUNCTIONS. One or more appropriately qualified persons are designated to see that the following essential functions of a low vision service are performed *(check those functions carried out by designated personnel):*

___ Admissions processing

___ Medical (including ophthalmological) evaluation and referral

___ Psychosocial evaluation, treatment and referral

___ Clinical examination and prescription of low vision aids (ophthalmological and/or optometric functions)

___ Individualized instruction/training in use of prescribed low vision aids

___ Referrals for other services

___ Followup services

___ Administration and supervision of office systems

Comments:

( ) 2.2 SPECIFIC PREPARATION IN LOW VISION SERVICE. All employees, consultants and volunteers have been given specific preparation and training in low vision service appropriate for their assignments.

( ) 2.2.1 Staff Development. Staff development activities are planned and provided for all categories of personnel in accordance with *Section C-3 Personnel Administration and Volunteer Service.*

( ) 2.2.2 Continuing Education. Each person is encouraged to take advantage of appropriate continuing education opportunities in low vision service.

Comments:

SUPPLEMENTARY INFORMATION. Personnel from various professions and specialties are utilized in a low vision service. Such personnel should be appropriately qualified as defined by applicable State statutes or by national voluntary certification programs maintained by professional groups.

Personnel from some of these professions or specialties are of key significance and may be members of the low vision service staff. Others may be available from another part of the "parent" agency or an "outside" organization.

Check below those professions or specialties made available by the staff assigned to the low vision service; by referral to another unit within the "parent" agency or by referral to "outside" organizations.

KEY PROFESSIONS OR SPECIALTIES AVAILABLE

Profession or Specialty	By Staff of this Service	By other Unit of Parent Agency	By Outside Referral	
			Check	Name of Organization
Low vision assistant	___	___	___	_____
Ophthalmology	___	___	___	_____
Optometry	___	___	___	_____
Orientation and mobility	___	___	___	_____
Psychology	___	___	___	_____
Rehabilitation counseling	___	___	___	_____
Rehabilitation teaching	___	___	___	_____
Social work	___	___	___	_____
Special education of blind and visually handicapped children	___	___	___	_____

Comments:

SUPPLEMENTARY INFORMATION (continued).

OTHER PROFESSIONS OR SPECIALTIES MADE AVAILABLE AND UTILIZED

Profession or Specialty	By Staff of this Service	By other Unit of Parent Agency	By Outside Referral: Check	By Outside Referral: Name of Organization
Audiology	___	___	___	_____
Bio-engineering	___	___	___	_____
Genetic counseling	___	___	___	_____
Nursing	___	___	___	_____
Occupational therapy	___	___	___	_____
Opticianry	___	___	___	_____
Patient advocacy	___	___	___	_____
Physical therapy	___	___	___	_____
Recreation	___	___	___	_____
Various specialties of medicine (specify)				
_____	___	___	___	_____
_____	___	___	___	_____
_____	___	___	___	_____
_____	___	___	___	_____
_____	___	___	___	_____
Other (specify)				
_____	___	___	___	_____
_____	___	___	___	_____
_____	___	___	___	_____
_____	___	___	___	_____
_____	___	___	___	_____

Comments:

( ) 2.3 ADMINISTRATOR. The organization employs as administrator of the service a person who has demonstrated competencies to administer, coordinate and supervise day-to-day operations including *(check those responsibilities assigned to the administrator):*

____ Assuring that all patients have received medical eye examinations and care appropriate to their eye conditions within a reasonable period of time before low vision services are commenced

____ Scheduling of patients, clinician(s), and assistant(s)

____ Assuring that established policies and procedures are followed

____ Maintaining records, reports and administrative functions in an efficient and cost effective manner

Comments:

( ) 2.4 CLINICAL DIRECTOR OF LOW VISION SERVICE. A licensed ophthalmologist or optometrist is responsible for providing general direction of low vision clinical care practices and quality including *(check those responsibilities assigned to the clinical director of low vision service):*

____ Assuring that proper clinical procedures are followed for clinical examinations

____ Assuring that proper clinical procedures are observed in instruction/training and followup activities

____ Assuring that inservice training activities include appropriate low vision information

____ Assuring that timely and proper clinical records and reports are prepared and reviewed

____ Monitoring and maintaining professional relations with other professions, specialties and services

____ Determining need for referral back to the patient's primary medical care provider if there is evidence of a deteriorating condition or signs of a decrease in vision during any phase of the low vision service

Comments:

( ) 2.5 LOW VISION CLINICIAN. One or more licensed ophthalmologists and/or optometrists provide clinical low vision services including *(check those duties assigned to the low vision clinician):*

____ Performing clinical examinations and prescribing low vision aids

____ Providing instruction and training in use of prescribed low vision aids and followup of their effectiveness

____ Directing and supervising the work of low vision assistants

Comments:

( ) 2.6 LOW VISION ASSISTANT. One or more low vision assistants provide instruction to patients in the use of prescribed low vision aids to improve visual performance under the direction and supervision of a low vision clinician.

Comments:

( ) 2.7 OPHTHALMOLOGICAL CONSULTANT. A licensed ophthalmologist is available to provide consultation on reports of ophthalmological and other medical examinations and care to determine whether there are medical contraindications to low vision service.

Comments:

( ) 2.8 OPTOMETRIC CONSULTANT. A licensed optometrist is available to provide consultation on optometric matters.

Comments:

( ) 2.9 CLERICAL AND OTHER SUPPORT SERVICES. One or more clerks or secretaries and other support staff are employed in numbers sufficient for the volume of patients served.

Comments:

( ) 2.10 VOLUNTEERS. The use of volunteers, including persons who have low vision, is governed in accordance with *Section C-3, Personnel Administration and Volunteer Service.*

Comments:

PART 3. LOW VISION EVALUATION

( ) 3.1 SCOPE. Each patient receives a low vision evaluation consisting of a clinical examination, consideration for a prescription of a low vision aid, initial instruction and assessment of any prescribed aid(s) and appropriate referral to other services, when indicated.

Comments:

( ) 3.2 BACKGROUND INFORMATION. Provision is made to secure sufficient information about the patient's medical history, visual activities and how the patient believes low vision aids can help.

( ) 3.2.1 Social History. To the extent needed, a focused history is obtained of the patient's social, educational, vocational, recreational and daily living activities.

( ) 3.2.1.1 Data from the social history are used in planning service on an individualized basis.

( ) 3.2.1.2 The process is designed to help the patient develop realistic expectations about the low vision service.

Comments:

( ) 3.2.2 Medical History. If needed, additional medical history is obtained to augment the findings of the recent ophthalmological report.

Comments:

( ) 3.2.3 Review. The low vision clinician reviews the available background information in preparation for the clinical examination.

Comments:

( ) 3.3 CLINICAL EXAMINATION. The clinical examination is conducted by a low vision clinician.

( ) 3.3.1 Basic Procedures. The clinical examination includes the following basic procedures for assessment of a variety of variables *(check those regularly included)*:

___ History and confirmation of the medical diagnosis and interpretation of the functional effects of diagnosed pathology.

___ Determination of visual acuity at near, intermediate and far distances

___ Confirmation of refractive errors

___ Interpretation of the functional effects of visual fields

___ Assessment of color vision

___ Evaluation of the effects of various light levels

___ Assessment of the effects of ocular mobility and binocularity

___ Determination of magnification needs

___ Ophthalmologic and/or optometric consultation when indicated

Comments:

( ) 3.3.2 Additional Procedures. Additional clinical examination procedures are provided or secured from other sources when needed.

SUPPLEMENTARY INFORMATION. Check additional procedures made available and sources.

Procedures	*By Staff of This Service*	*By Other Unit of Parent Agency*	*By Other Sources*	
			Check	*Name or Organization*
Additional medical diagnostic services	___	___	___	_____
Biomicroscopy	___	___	___	_____
Dark adaptation	___	___	___	_____
Hearing assessment	___	___	___	_____
Tonometry	___	___	___	_____
Other (specify)				
_____	___	___	___	_____
_____	___	___	___	_____

Comments:

( ) 3.3.3 Re-referral. Whenever indicated, the patient is referred back to the primary medical care provider.

Comments:

( ) 3.4 PRELIMINARY PRESCRIPTION. Utilizing the findings of the clinical examination, the low vision clinician makes a decision whether or not the patient is likely to benefit from optical or non-optical low vision aid(s).

( ) 3.4.1 Types of Aids. Consideration is given to various types of aids including *(check those regularly considered):*

___ Absorptive lenses or filters ___ Distant vision aid(s)

___ Intermediate range aid(s) ___ Near vision aid(s)

Comments:

( ) 3.4.2 Recommendation. The low vision clinician makes a recommendation or a preliminary prescription of special lenses, aids, devices or techniques to be used in initial instruction and assessment of function.

( ) 3.4.2.1 The written recommendation is prepared and shared with personnel who provide initial instruction and assessment of function.

( ) 3.4.2.2 The patient for whom an optical aid is not indicated is considered for other services and/or referral to another resource whenever indicated.

Comments:

( ) 3.5 INITIAL INSTRUCTION AND ASSESSMENT OF FUNCTION. As part of the clinical examination, or as soon thereafter as possible, the patient is given initial instruction in the proper use of the recommended aid(s) and an assessment of the usefulness of the aid(s) is begun.

( ) 3.5.1 Scope of Instruction. Initial instruction encompasses the physical and optical properties of the aid(s), and the use of the aid(s) for various purposes under different environmental conditions relevant to the patient's expressed needs and interests.

Comments:

( ) 3.5.2 Assignment of Responsibility. Responsibility for initial instruction is assigned to the low vision clinician or to the low vision assistant or a combination of both.

Comments:

( ) 3.5.3 Individual Patient Objectives. Instruction is progressive and individualized according to the patient's sensory, perceptive and cognitive capacities, interests and needs including the effective use of residual vision with and without aids.

Comments:

( ) 3.5.4 Patient Responses. Indications for possible modification of the preliminary prescription which are detected from the patient's responses during initial instruction and evaluation of function of the trial aid(s) are reviewed by the low vision clinician.

Comments:

( ) 3.5.5 Loan Service. A comprehensive stock of commonly used aids is maintained for loan to patients to test out under everyday circumstances.

Comments:

( ) 3.6 ADDITIONAL INSTRUCTION AND TRAINING. Provision is made for the patient to receive additional instruction and training in the use of the trial aid(s), when indicated, as a regular part of the low vision evaluation.

( ) 3.6.1 Scope. The scope of additional instruction and training includes the answering of the patient's questions in use of the aid(s), instruction designed to improve skill in using the aid(s) and increasing the patient's motivation to use the aid(s).

Comments:

( ) 3.6.2 Assignment of Responsibility. Responsibility for additional instruction and training is assigned to the low vision clinician or to the low vision assistant or to a combination of both.

Comments:

( ) 3.6.3 Length of Instruction and Training. The length of time or number of sessions is individually determined according to the patient's expressed interest, visual capacities and the number and types of trial aids.

Comments:

( ) 3.7 CONCLUSION OF LOW VISION EVALUATION. The low vision evaluation concludes upon completion of initial instruction and assessment of function of the preliminary prescription including any modification(s) by the low vision clinician.

Comments:

PART 4. CONTINUING SERVICES

( ) 4.1 OTHER SPECIALIZED INSTRUCTION, TRAINING AND SERVICES. Provisions are made for the patient to receive other specialized instruction, training and services when needed to make optimum use of low vision aids in a variety of situations.

Comments:

( ) 4.1.1 Orientation and Mobility. If the patient has problems in making effective use of the prescribed low vision aid(s) in orientation and mobility, especially for active travel, services are made available according to *Section D-2A, Orientation and Mobility Services.*

Comments:

( ) 4.1.2 Recreation and Leisure Services. If the patient has problems in making effective use of the prescribed low vision aid(s) in recreation and leisure activities, appropriate services are made available according to *Section D-5, Social Services.*

Comments:

( ) 4.1.3 Rehabilitation Teaching. If the patient has problems in making effective use of the prescribed low vision aid(s) in developing adaptive skills for living, appropriate services are made available according to *Section D-8, Rehabilitation Teaching Services.*

Comments:

( ) 4.1.4 Social Work. If the patient has problems in making effective use of the prescribed low vision aid(s) because of difficulties with interpersonal relationships, obtaining community services or entering "mainstream" activities, appropriate services are made available according to *Section D-5, Social Services.*

Comments:

( ) 4.1.5 Special Education. If the patient is of preschool and school age, qualified teachers of blind and visually handicapped students are involved to assist the student in making effective use of the prescribed low vision aid(s) in education.

Comments:

( ) 4.1.6 Vocational Services. If the patient has problems in making effective use of the prescribed low vision aid(s) at work or expresses interest in exploring possibilities of vocational placement, appropriate services are made available according to *Section D-6, Vocational Services.*

Comments:

( ) 4.1.7 Workshop Services. If the patient receives workshop services and has problems making effective use of the prescribed low vision aid(s) at the workplace, appropriate services are made available according to *Section D-4, Workshop Services.*

Comments:

( ) 4.1.8 Other Services. If other services appear needed for the patient to make effective use of the prescribed low vision aid(s), appropriate arrangements are made whenever possible.

Comments:

SUPPLEMENTARY INFORMATION. Enter below the number of patients who receive continuing services from members of the staff of this low vision service, by referral to another unit within the "parent" agency or through specified "outside" organizations or services. Because a patient may receive more than one of these services, the totals may exceed the total number of patients served.

NUMBER OF PERSONS RECEIVING CONTINUING SERVICES

FOR THE FISCAL YEAR ENDING _____.

Type of Continuing Service	*By Staff of This Service*	*By Other Unit of Parent Agency*	*By Outside Referral*	
			Number	*Name of Organization*
Orientation and mobility	___	___	___	_____
				_____
Recreation and leisure service	___	___	___	_____
				_____
Rehabilitation teaching	___	___	___	_____
				_____
Social work	___	___	___	_____
				_____
Special education	___	___	___	_____
				_____
Vocational services	___	___	___	_____
				_____
Workshop services	___	___	___	_____
Other (specify)				
_____	___	___	___	_____
_____	___	___	___	_____
_____	___	___	___	_____

Comments:

( ) 4.2 COMPLETION OF SERVICE. The low vision service is completed by determination of the final prescription of the low vision aid(s) for the patient.

( ) 4.2.1 Modification of the Preliminary Prescription. Feedback is given to the low vision clinician by the low vision assistant and/or the referral source concerning the suitability or possible need for modification of the preliminary prescription.

Comments:

( ) 4.2.2 Final Prescription. The final prescription is made by the low vision clinician based on evaluations by the patient, low vision clinician, low vision assistant and the referral source, resulting in a decision that the correct aid(s) have been selected, properly fitted and that the patient has learned to use them effectively.

Comments:

( ) 4.2.3 Disposition of Loaner. Any loaner aid(s) are returned or purchased when the final prescription is dispensed.

Comments:

( ) 4.2.4 Confirmation. Followup is made with the patient to confirm the effectiveness of the service.

Comments:

( ) 4.2.5 Closure. The reason for completion or non-completion of service is recorded when service ends.

Comments:

( ) 4.3 REEVALUATION AND MAINTENANCE OF PATIENT CONTACT. Provisions are made for reevaluations and maintenance of contact with the patient after completion of service.

Comments:

( ) 4.3.1 Re-visits. Patients are informed prior to completion of service of the policies and procedures concerning the availability, timing and duration of re-visits for reevaluations.

) 4.3.1.1 Reevaluation visits are offered by the low vision service on an individualized basis when there is indication of a need to maintain contact with the patient to assure continuing effectiveness of the service.

( ) 4.3.1.2 Provisions are made for patients who have completed service to request reevaluation.

Comments:

( ) 4.3.2 Reevaluation Process. The process of admissions, low vision evaluation and continuing services are comparable to those used for new patients.

Comments:

PART 5. FACILITIES AND EQUIPMENT

( ) 5.1 ACCESSIBILITY. Low vision facilities are located, designed and operated to optimize their use by low vision patients, according to *Section C-4, Physical Facilities*.

Comments:

( ) 5.2 CAPACITY FOR SERVICE. The hours of service and the number of patient visits which can be accomodated are sufficient to meet the stated program objectives.

Comments:

( ) 5.3 SPACE. Facilities are adequate in size and functional in design.

Comments:

( ) 5.3.1 Waiting Area. A comfortable waiting area is provided with reasonable access to lavatory facilities.

Comments:

( ) 5.3.2 Clinical Examination Room. One or more rooms, free from outside distractions, are provided for conducting clinical examinations.

Comments:

( ) 5.3.2.1 The size is adequate for necessary equipment, supplies and appropriate seating for the low vision clinician, patient and other significant persons.

Comments:

( ) 5.3.2.2 An unobstructed, 10 foot lane is provided for examinations, and a 20 foot lane or its equivalent is available for distance evaluations.

Comments:

( ) 5.3.2.3 Lighting is controllable, on a continuously variable basis, from darkness to very bright.

Comments:

( ) 5.3.3 Instruction Area. One or more rooms or other suitable area(s), free from outside distractions, are provided for instruction, training and evaluation of function.

( ) 5.3.3.1 The instruction area is furnished with tables, chairs, variable lighting and other appropriate equipment and materials.

Comments:

( ) 5.3.4 Office Area. Suitably equipped and supplied office and admissions processing space is provided which is adequate for the number of persons served.

Comments:

( ) 5.3.5 Storage and Stock Area. Sufficient space and cabinets are provided for safe, secure and efficient storage of demonstration and loaner aids, materials, devices, records, spare bulbs, batteries and other stock.

Comments:

( ) 5.4 BASIC EXAMINING EQUIPMENT. The service maintains in good working order the following basic examining equipment and materials *(check those available):*

___ Acuity charts for near and far vision
___ Amsler grid
___ Color identification materials
___ Contact lenses
___ Occluders
___ Ophthalmoscope
___ Retinoscope
___ Keratometer
___ Trial frames
___ Trial lenses and cross cylinders
___ Transilluminator
___ Visual field testing equipment

Comments:

( ) 5.4.1 Additional Equipment. Additional examining equipment is provided as needed.

SUPPLEMENTARY INFORMATION. Check additional examining equipment available:

___ *Binocular indirect ophthalmoscope*
___ *Optokinetic drum or tape*
___ *Phoropter/refractor*
___ *Slit lamp*
___ *Standard perimeter*
___ *Tonometer*
___ *Other (specify)*
_____

Comments:

( ) 5.5 BASIC PRINTED MATERIAL AND AIDS FOR INSTRUCTION. The following basic printed materials and aids are available for demonstration and instruction purposes *(check those available):*

___ Absorptive lenses/filters
___ Hand-held magnifiers
___ High plus lenses
___ Lamps
___ Large print samples
___ Loupes
___ Press-on prisms
___ Reading materials for various ages and reading levels.
___ Stand magnifiers
___ Telescopes, monocular and binocular, of various powers, for distant vision
___ Telescopes, monocular and binocular, of various powers, for intermediate vision
___ Telescopes, monacular and binocular, of various powers, for near vision

Comments:

( ) 5.5.1 Additional Aids and Materials. Additional optical and non-optical aids and instructional materials are available as needed.

SUPPLEMENTARY INFORMATION. Check additional aids and materials available.

___ *Electronic aids (e.g. closed circuit television)*

___ *Night viewing devices*

___ *Non-optical aids (e.g. hand calculator, reading stand)*

___ *Sample printed materials*

___ *Toys, games, crafts etc.*

___ *Other (specify)* _____

Comments:

( ) 5.5.2 Loan Equipment and Materials. A comprehensive stock is maintained for loan to patients of instructional materials and commonly used optical aids of various types and powers.

Comments:

( ) 5.6 MAINTENANCE. Provisions are made for on-going maintenance, repair, recalibration, replacement and inventory control of instruments, equipment and materials.

Comments:

( ) 5.7 REFERENCE COLLECTION. A collection of reference books and other materials on low vision is maintained for personnel of the service.

Comments:

PART 6. PROGRAM EVALUATION

( ) 6.1 PURPOSE. A practical and on-going system is used to evaluate the effectiveness and efficiency of the service and the findings are used to effect needed improvements.

Comments:

( ) 6.2 SCOPE OF EVALUATION. Program evaluation is systematic and encompasses all relevant factors affecting the low vision service.

( ) 6.2.1 Long Range Plan. Progress toward reaching the long range objectives of the low vision service is summarized in writing each year and the findings used in revising and extending the long range plan.

Comments:

( ) 6.2.2 Annual Plan. Each year, the achievements of the service are evaluated against the specific objectives established for it in the annual program and financial plan and the findings are used in developing the next year's plan.

Comments:

( ) 6.2.3 Resources. Evaluations of the service encompass the adequacy of available resources including finances, personnel, facilities, materials, and equipment.

Comments:

( ) 6.2.4 Patient Outcomes. Provisions are made for evaluating the effectiveness of the low vision service for individual patients.

( ) 6.4.2.1 Data on functioning before and after service are incorporated in the evaluations of patient outcomes, from the point of application through all phases of service including followup.

Comments:

( ) 6.2.5 Professional Development. The effectiveness and adequacy of activities for professional development of low vision service staff and consultants are evaluated.

Comments:

( ) 6.2.6 Effectiveness of Program Evaluation. The systems for evaluating the low vision service are themselves evaluated, from time to time, in terms of efficiency and effectiveness in achieving their purposes.

Comments:

( ) 6.3 COORDINATION. Evaluations of the service are conducted by means of established systems which include designation of a person to coordinate the evaluation.

Comments:

( ) 6.4 PEER REVIEW. An on-going system of peer review is organized and implemented in accordance with accepted professional practices.

Comments:

( ) 6.5 PARTICIPATION IN EVALUATION. Structured processes are used to assure meaningful input to program evaluation activities from persons who represent a wide range of knowledge, experience and interest including the organization's governing authority, staff, consultants, service volunteers, persons served and other consumers and the community.

Comments:

( ) 6.6 INDEPENDENT EVALUATIONS. The organization makes provision for independent evaluations of the low vision service from time to time, as deemed necessary and desirable.

Comments:

( ) 6.7 UTILIZATION OF FINDINGS. Evaluation findings are summarized in writing and systematically used in planning, budgeting, and making and documenting indicated changes in internal and public reporting activities pertaining to low vision service.

Comments:

SUPPLEMENTARY INFORMATION. PROGRAM EVALUATION CHECK LIST. Check those factors included in evaluations of the low vision service during the last fiscal year.

___ *Philosophy*

___ *Purpose*

___ *Persons served*

___ *Admissions procedures*

___ *Planning*

___ *Participation in planning*

___ *Organization*

___ *Essential functions*

___ *Specific preparation in low vision services*

___ *Administrator*

___ *Clinical director*

___ *Low vision clinician*

___ *Low vision assistant*

___ *Ophthalmological consultant*

___ *Optometric consultant*

___ *Clerical and other support services*

___ *Volunteers*

___ *Scope of low vision evaluation*

___ *Background information*

___ *Clinical examination*

___ *Preliminary prescription*

___ *Initial instruction and assessment of function*

___ *Additional instruction and training*

___ *Conclusion of low vision evaluation*

___ *Other specialized instruction, training and services*

___ *Completion of service*

___ *Reevaluation and maintenance of patient contact*

___ *Accessibility*

___ *Capacity for service*

___ *Space*

___ *Examining equipment*

___ *Printed materials and aids for instruction*

___ *Maintenance*

___ *Reference collection*

___ *Purpose of program evaluation*

___ *Scope of evaluation*

___ *Peer review system*

___ *Participation in program evaluation*

___ *Independent evaluations*

___ *Utilization of findings*

___ *Programming for improvement*

___ *Other (specify)*

Comments:

PROGRAMMING FOR IMPROVEMENT

Programming for improvement is a continuous cycle of planning, implementing and evaluating. Because accreditation is a structured method of evaluating and planning, it enhances the organization's capacity to effect improvement when meshed with the normal program and fiscal planning, and evaluation processes.

This final part of the guide consists of seven questions designed to summarize and report on the principal findings of the self-study of this service. Such a summary helps the on-site review team understand and report on the recent achievements of and plans for the service.

Question one elicits a list of features which are deemed to be the most outstanding.

Questions two through six are designed to help the organization summarize its program for improvement on the basis of ideas generated by the self-study. They start with a review of the recent past, proceed through the present, and project into the future.

Questions four through six focus specifically on developing a timetable for improvements which reflects, or can be incorporated into, the organization's normal planning system, thus taking advantage of the momentum created by the NAC self-study.

Question seven asks about the beneficial impact of the service on the lives of the persons served. Data from recent studies of patient outcomes and from broadly based input from participants in the self-study will be helpful in preparing this statement.

Careful attention to the answers to these seven questions will help the Commission on Accreditation in applying the following principle: if deficiencies exist, the organization is aware of them and shows a commitment to make the needed improvements in a reasonable amount of time.

*1. **What are the outstanding features of the service at this time?***

2. *What improvements or other changes were made in the fiscal periods from five years ago through two years ago?*

3. *What improvements or other changes were made in the most recently completed fiscal year?*

4. *What improvements or other changes have been introduced in the current fiscal year? (Indicate which were made as a result of the self-study. Also, if they have not yet been completed, indicate when completion is expected.)*

5. *What improvements are included in the program plan and budget for next fiscal year?*

6. *What additional improvements are contemplated in the long range plan?*

7. What impact has this service had on the persons served?

MEMBERS OF SELF-STUDY SUBCOMMITTEE

Name	Identification (job title, board member, consumer, etc.)
Chairman: _____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Date completed by Subcommittee _____

Date accepted by Coordinating Committee _____

Organization Name _____

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